The Safety Net Foundation
Providing assistance to those in need.

FACILITY APPLICATION FORM

Instructions: This form should be completed by a facility contact to begin the facility enrollment processs into The Safety Net Foundation. A facility must enroll in The Safety Net Foundation in order to participate in the product replacement program. This form only needs to be submitted once per facility.

Facility Mailing Information *(address where you would like written communication mailed)*

Facility Name:______________________________

Address 1:______________________________

Address 2:______________________________

City:____________________ State:____________________ Zip Code:____________________

Please indicate the facility type:

________Community Pharmacy ________Free Standing Dialysis Center ________Hospital

________Hospital Dialysis Center ________Hospital Pharmacy ________Infusion Facility

________Provider's Office ________Specialty Pharmacy

Facility HIN #:______________ DEA #:______________ AHA #:______________ NPI #:______________

Note: The Safety Net Foundation cannot provide assistance for inpatient hospital use.

Facility Mailing Contact Information

Contact First Name:____________________ Contact Last Name:____________________

Title:______________________________

Phone #:____________________ Fax #:____________________

Email Address:______________________________

Facility's Preferred Method of Written Communication (primary) – check only one: ☐ Email ☐ Fax ☐ Mail

Facility's Preferred Method of Written Communication (secondary) – check only one: ☐ Email ☐ Fax ☐ Mail

Facility Shipping Information *(address where you would like product shipped)*

☐ Check here if shipping address information is the same as the mailing information

Facility Name:______________________________

Address 1:______________________________
(PO BOX is not accepted)

Address 2:______________________________
(PO BOX is not accepted)

City:____________________ State:____________________ Zip Code:____________________

Facility Shipping Contact Information

☐ Check here if shipping contact information is the same as the mailing information

Shipping Contact First Name:____________________ Shipping Contact Last Name:____________________

Title:______________________________

Phone #:____________________ Fax #:____________________

Facility Name:____

Third Party Administrator Information

If your facility uses a third party administrator (TPA) to facilitate processing for patient assistance programs, please complete the information below:

☐ Send communications to TPA in addition to Facility

Company Name:____

Contact First Name:____________________ Contact Last Name:____________________

Title:____

Address 1:____

Address 2:____

City:________________ State:________________ Zip Code:________________

Phone #:________________ Fax #:________________

Email Address:______________________________

TPA’s Preferred Method of Written Communication (primary) – check only one: ☐ Email ☐ Fax ☐ Mail

TPA’s Preferred Method of Written Communication (secondary) – check only one: ☐ Email ☐ Fax ☐ Mail

Pharmacy Director Information

If your facility has a Pharmacy Director, please list his/her name (required for facilities that use Third Party Administrators):

Pharmacy Director First Name:____________________ Pharmacy Director Last Name:____________________

Title:____

Address 1:____

Address 2:____

City:________________ State:________________ Zip Code:________________

Phone #:________________ Fax #:________________

Email Address:______________________________

Pharmacy Director’s Preferred Method of Written Communication (primary) – check only one: ☐ Email ☐ Fax ☐ Mail

Pharmacy Director’s Preferred Method of Written Communication (secondary) – check only one: ☐ Email ☐ Fax ☐ Mail

For Internal Use Only

The Safety Net Foundation Customer Number:______________________________

FACILITY CERTIFICATION FORM

Facility Name:____

By submitting this application, I agree to the following:

- I will provide Amgen products for patients in a medically appropriate manner based on a valid physician's order or prescription.
- I understand that The Safety Net Foundation reserves the right to change or terminate this program at any time, or to refuse to distribute Amgen products under this program to any patient or facility.
- I understand that product is provided on a replacement basis. Participating providers are required to stock the product and apply for replacement product through The Safety Net Foundation.
- I understand that an insurance verification may be required to determine a patient's eligibility for The Safety Net Foundation.
- I understand that the product received through The Safety Net Foundation is for medically needy patients living in the United States and its territories.
- I certify that I will not charge or cause any other party to charge any third party or patient for Amgen products for which replacement is sought under The Safety Net Foundation. I further certify that all product received in connection with The Safety Net Foundation will replace such product; be furnished free of charge for treatment of needy patients who meet The Safety Net Foundation criteria; and, that no part of any charges for Amgen products replaced under The Safety Net Foundation will be claimed as bad debt.
- I understand that The Safety Net Foundation is available for outpatient use only. I certify that no replacement will be requested for product administered in the hospital inpatient setting.
- I represent that the information contained in all patient applications under my facility, including the patient application form will be complete and accurate to the best of my knowledge. This representation does not require my independent investigation of the information. If I become aware of any changes in the patient's circumstances that affect Safety Net Foundation eligibility, I agree to notify The Safety Net Foundation immediately.
- I agree to release or make available to an authorized Safety Net Foundation representative the medical and financial records for Safety Net Foundation patients who have provided consent for such disclosure for the sole purpose of verifying patients' eligibility for The Safety Net Foundation. I agree that I will not provide patient information without obtaining appropriate consent from each patient prior to releasing or making available to The Safety Net Foundation such records or information.
- I further certify that I am authorized to act for the institution for which I am signing.

Signature of Facility's Authorized Representative:______________________________ Date:____________________

Title:____

Send completed forms to:

The Safety Net Foundation
PO BOX 13185
La Jolla, CA 92039-3185
Phone: 888/SN-AMGEN (888/762-6436) Fax: 866/549-7239